Appendix 16
Oral and Maxillofacial Surgery Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Extractions (includes local anesthesia and routine postoperative care):				
07110	Single tooth	No	All	Allowed only once per tooth (tooth numbers 1-32, A-T, SN). Not billable same day as 07250.
Surgical Extractions (includes local anesthesia and routine postoperative care):				
07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No	All	Allowed only once per tooth. Covered when performing an *emergency* service or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.
07220	Removal of impacted tooth - soft tissue	No	All	Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.
07230	Removal of impacted tooth - partial bony	No	All	Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.
07240	Removal of impacted tooth - completely bony	No	All	Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1] Not billable same day as 07250.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
07250	Surgical removal of residual tooth roots (cutting procedure)	No	All	*Emergency only* (tooth numbers 1-32, A-T, SN).[1] Allowed only once per tooth. Not allowed on the same day as tooth extraction of same tooth number.
Other Surgical Procedures:				
07260 or CPT[2]	Oroantral fistula closure	No	All	
07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	No	All	*Emergency only* (tooth numbers 1-32, C-H, M-R, SN).[1]
07280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	Yes	< 21	HealthCheck referral is required. Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, SN only).
07281	Surgical exposure of impacted or unerupted tooth to aid eruption	Yes	< 21	HealthCheck referral is required. Not allowed for wisdom teeth (tooth numbers 2-15, 18-31, A-T, SN only).
07285 or CPT[2]	Biopsy of oral tissue - hard	No	All	Once per day.**
07286 or CPT[2]	Biopsy of oral tissue - soft	No	All	Once per day.**

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Removal of Tumors, Cysts, and Neoplasms:				
07430 or CPT[2]	Excision of benign tumor - lesion diameter up to 1.25 cm	No	All	Once per day.**
07431 or CPT[2]	Excision of benign tumor - lesion diameter greater than 1.25 cm	No	All	Once per day.**
07440 or CPT[2]	Excision of malignant tumor - lesion diameter up to 1.25 cm	No	All	Pathology report required.
07441 or CPT[2]	Excision of malignant tumor - lesion diameter greater than 1.25 cm	No	All	Pathology report required.
07450 or CPT[2]	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No	All	Pathology report required.
07451 or CPT[2]	Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No	All	Pathology report required.
07460 or CPT[2]	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	No	All	Pathology report required.
07461 or CPT[2]	Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No	All	Pathology report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Excision of Bone Tissue:				
07470 or CPT[2]	Removal of exostosis - maxilla or mandible	Yes	All	Operative report required.
07480 or CPT[2]	Partial ostectomy (guttering or saucerization)	No	All	Operative report required.
07490 or CPT[2]	Radical resection of mandible with bone graft	No	All	Operative report required. Only allowable in place of service 0, 1, 2, or B.
Surgical Incision:				
07510 or CPT[2]	Incision and drainage of abscess - intraoral soft tissue	No	All	Operative report required. Not to be used for periodontal abscess - use W7118.
07520 or CPT[2]	Incision and drainage of abscess - extraoral soft tissue	No	All	Operative report required.
07530 or CPT[2]	Removal of foreign body, skin, or subcutaneous areolar tissue	Yes, unless provided to hospital inpatient	All	Not allowed for root fragments or bone spicules. Operative report required.
07540 or CPT[2]	Removal of reaction-producing foreign bodies - musculoskeletal system	Yes, unless provided to hospital inpatient	All	Not allowed for root fragments or bone spicules. Operative report required.
07550 or CPT[2]	Sequestrectomy for osteomyelitis	No	All	Operative report required.
07560 or CPT[2]	Maxillary sinusotomy for removal of tooth fragment or foreign body	No	All	Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Treatment of Fracture - Simple:				
07610 or CPT[2]	Maxilla - open reduction (teeth immobilized, if present)	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07620 or CPT[2]	Maxilla - closed reduction (teeth immobilized, if present)	No	All	Operative report required.
07630 or CPT[2]	Mandible - open reduction (teeth immobilized, if present)	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07640 or CPT[2]	Mandible - closed reduction (teeth immobilized, if present)	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07650 or CPT[2]	Malar and/or zygomatic arch - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07660 or CPT[2]	Malar and/or zygomatic arch - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07670 or CPT[2]	Alveolus - stabilization of teeth, open reduction splinting	No	All	Operative report required.
07680 or CPT[2]	Facial bones - complicated reduction with fixation and multiple surgical approaches	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Treatment of Fractures - Compound:				
07710 or CPT[2]	Maxilla - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07720 or CPT[2]	Maxilla - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07730 or CPT[2]	Mandible - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07740 or CPT[2]	Mandible - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07750 or CPT[2]	Malar and/or zygomatic arch - open reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07760 or CPT[2]	Malar and/or zygomatic arch - closed reduction	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07770 or CPT[2]	Alveolus - stabilization of teeth, open reduction splinting	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07780 or CPT[2]	Facial bones - complicated reduction with fixation and multiple surgical approaches	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Reduction of Dislocation and Management of Other TMJ Dysfunctions:				
07810 or CPT[2]	Open reduction of dislocation	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07820 or CPT[2]	Closed reduction of dislocation	No	All	Once per day.**
07830 or CPT[2]	Manipulation under anesthesia	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07840 or CPT[2]	Condylectomy	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
07850 or CPT[2]	Surgical discectomy; with/without implant	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
07860 or CPT[2]	Arthrotomy	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
W7995	Initial consultation, TMJ (TMJ multi-disciplinary evaluation program use only)	No	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report required.
W7996	Follow-up consultation, TMJ (TMJ multidisciplinary evaluation program use only)	No	All	Allowed once per year, per multidisciplinary TMJ evaluation program. Allowable in place of service 1, 2, or 3.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
W7998 or CPT[2]	TMJ assistant surgeon	Yes	All	Procedure must be included in PA request for the surgery itself. Only allowable in place of service 1, 2, or B.
Repair of Traumatic Wounds:				
07910 or CPT[2]	Suture of recent small wounds up to 5 cm	No	All	*Emergency only* - operative report required.
Complicated Suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure):				
07911 or CPT[2]	Complicated suture - up to 5 cm	No	All	Covered for *trauma (emergency) situations only.*[1] Operative report required.
07912 or CPT[2]	Complicated suture - greater than 5 cm	No	All	Covered for *trauma (emergency) situations* only.[1] Once per day.** No operative report required, unless same day as surgery.
Other Repair Procedures				
07940 or CPT[2]	Osteoplasty - for orthognathic deformities	Yes	< 21	HealthCheck referral required. Only allowable in place of service 1, 2, or B. No operative report required.
07950 or CPT[2]	Osseous, osteo-periosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, 3, or B. No operative report needed.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
07960 or CPT[2]	Frenulectomy (frenectomy or frenotomy) - separate procedure	Yes	< 21	HealthCheck referral required. No operative report needed.
07970 or CPT[2]	Excision of hyperplastic tissue - per arch	Yes	All	No operative report needed.
07980 or CPT[2]	Sialolithotomy	No	All	Only allowable in place of service 0, 1, 2, 3, or B. Operative report required.
07991 or CPT[2]	Coronoidectomy	Yes	All	Multidisciplinary TMJ evaluation required. Only allowable in place of service 1, 2, or B. No operative report needed.
07999 or CPT[2]	Unspecified oral surgery procedure, by report	Yes	All	For medically necessary oral and maxillofacial procedures not included in Appendix 16. Does not include alveoplasty, vestibuloplasty, or other procedures not covered by Wisconsin Medicaid. Operative report required.

Key:

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

ORAL AND MAXILLOFACIAL SURGERY EXCEPT TMJ

COVERED SERVICES

DEFINITION

Wisconsin Medicaid may cover oral and maxillofacial surgical services due to trauma or congenital malformations such as clefts, or the removal of pathologic, painful, or non-restorable teeth. Corrective congenital surgery, such as orthognathic surgery, is limited to specific cases due to severe handicapping malocclusions.

SURGICAL EXTRACTION OF A TOOTH

Surgical extraction of a tooth is covered only when an extraction is necessary due to:

- An emergency which is a situation when an immediate service must be provided to relieve the recipient from pain, an acute infection, swelling, fever, or trauma.
- Orthodontia (for children up to age 21). In this case, prior authorization (PA) should be requested for the surgical extraction of a tooth in a non-emergency situation.

If during the routine extraction of any tooth the extraction unexpectedly becomes a surgical extraction, the surgical extraction is considered a dental emergency and will be covered. The procedure should be billed as an emergency and documentation of the circumstances must be kept in the recipient's records.

REPLANTATION AND SPLINTING

The replantation and splinting of a traumatically avulsed or subluxated tooth:

- Includes the post-operative follow-up.
- Includes the removal of any splints and wires.
- *Does not include any root canal therapy for the involved teeth.*

SUTURING

Suturing is:

- A covered benefit only when it is a result of a trauma.
- Not separately reimbursable when it is part of the surgery. In this case, it is included in the surgical procedure and fee.

When billing for suturing, the provider must include an operative report accurately describing the procedure, complexity of closure, location of laceration, and length of laceration(s) repaired.

PRIOR AUTHORIZATION

GENERAL INFORMATION

A study model may be requested by the dental consultant to aid in evaluating any PA request.

SURGICAL EXPOSURE OF AN IMPACTED OR UNERUPTED TOOTH

The surgical exposure of an impacted or unerupted tooth for orthodontic reasons includes placement of any hooks, wires, pins, etc., to aid eruption through orthodontics. This service includes placement of any orthodontic appliance on the impacted tooth.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

The documentation required for submitting the PA request is:

- A HealthCheck exam (the HealthCheck provider signature is required).
- A periapical radiograph of the tooth.

SURGICAL EXPOSURE OF A TOOTH TO AID ERUPTION

For the surgical exposure of a tooth to aid eruption, the tooth must be impacted by an adjacent tooth and not close to natural eruption. This service can be requested for primary and permanent teeth.

This service does *not* include placement of any hooks, wires, pins, etc., to aid eruption through orthodontics.

The documentation required for submitting the PA request is:

- A HealthCheck referral.
- A periapical radiograph of the tooth.

REMOVAL OF EXOSTOSIS MAXILLAE OR MANDIBLE

Criteria for PA approval include one of the following:

- The exostosis presents an undesirable undercut.
- The exostosis presents problems with insertion or stability of prosthesis.
- Medically necessary due to the presence of pain caused by the insertion or wearing of a removable prosthesis.

REMOVAL OF FOREIGN BODY

Removal of foreign body requires one periapical x-ray to accompany the PA request.

OSTEOPLASTY/ OSTEOTOMY

Osteoplasty/osteotomy for orthognathic deformities is provided for only the most severe orthodontic skeletal malocclusion. PA requests for correction of orthognathic deformities require a HealthCheck referral. Criteria for approval include one of the following:

- To correct the most severe cases of protruding or retruding mandible or maxillae where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct the most severe cases of open bite where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct a significant skeletal malocclusion where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct severe malocclusions caused by disease or injury where conventional orthodontics cannot provide a stable and acceptable outcome.

If the deformity has been caused by disease or injury, a physician's statement is required.

A HealthCheck referral is required for PA approval. The criteria for approval include a frenum which creates a central incisor diastema, ankyloglossia, periodontal defects, removable prosthodontic impairment, or is necessary to complete orthodontic services.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

EXCISION OF HYPERPLASTIC TISSUE

For the excision of hyperplastic tissue (per arch), the recipient must have an edentulous ridge and have difficulty wearing a prosthesis. The recipient must have adequate healing after tooth extraction before requesting this service. The service includes all local anesthetic, suturing, post-operative care, and soft tissue conditioning of any appliances at the time of surgery.

TMJ SURGERY

DEFINITION

The TMJ office visit requires detailed and extensive examination and documentation of the recipient's TMJ dysfunction.

A TMJ office visit consists of:

- A comprehensive history.
- Clinical examination.
- Diagnosis.
- Treatment planning.

INITIAL TREATMENT

The initial treatment of a TMJ dysfunction must consist of non-surgical treatments which include:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

The non-surgical TMJ treatments are not covered by Wisconsin Medicaid.

EVALUATION FOR TMJ SURGERY

When non-surgical TMJ therapy has failed to reduce TMJ dysfunction and pain, the recipient may request TMJ surgery. An oral and maxillofacial surgeon or physician surgeon can submit a PA request for TMJ surgery. The request must include an evaluation by a Department of Health and Family Services (DHFS)-approved Multidisciplinary TMJ Evaluation Program. A listing of the approved TMJ multi-disciplinary evaluation program sites is in Appendix 6 of this handbook. The initial TMJ consultation can be billed by the dentist performing the dental evaluation component of the evaluation program.

A follow-up consultation may be billed if necessary to clarify or review the findings and conclusions of the initial consultation.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

This evaluation must be provided by a facility not previously involved with the treatment of the recipient. The multi-disciplinary evaluation includes:

- A dental evaluation conducted by an oral and maxillofacial surgeon, orthodontist, or general practice dentist.
- A physical evaluation conducted by a neurologist, psychiatrist, or other physician knowledgeable regarding TMJ therapies.
- A psychological evaluation conducted by a psychiatrist or psychologist.

PRIOR AUTHORIZATION

TMJ EVALUATION

Documentation of the evaluation conclusions (including dentist's and physician's) must be included when the PA request is being submitted. All PA requests submitted for TMJ surgery must include a second opinion evaluation by a DHFS-approved multidisciplinary center. A PA request received without a multi-disciplinary evaluation will be returned. Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

To adequately provide a second opinion, the multidisciplinary center must have the necessary dental records on hand before seeing the recipient. The following materials must be at the second opinion location *before* the recipient's consultation visit:

- Any imaging procedures completed (MRI reports, x-rays, etc.).
- Operative notes addressing symptoms, findings, and diagnosis.
- Documentation of conservative care performed, including any occupational or physical therapy notes.
- Operative plan.
- Three to six-month postoperative plan of care.

TMJ CRITERIA FOR APPROVAL

PA criteria for approval include:

- Documentation of American Association of Oral and Maxillofacial Surgeries criteria.
- Documentation of second opinion.
- Favorable prognosis for surgery verified by second opinion.

ALL ORAL AND MAXILLOFACIAL SURGERY SERVICES BILLING

PRE- AND POST-CARE DAYS

Reimbursement for procedures directly related to an oral surgery is incorporated into reimbursement for the oral surgery procedure.

Palliative treatment, application of desensitizing medicaments, and other related procedures are not allowed at least three days before and 10 or more days after the surgery. Other procedures that are directly related to the surgery are not to be billed separately, no matter when the procedure is billed.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

However, if the procedure is not directly related to oral surgery, the limitation can be overridden with a narrative demonstrating that fact on the claim form. For example, the procedure may be done on a separate section of the mouth than the oral surgery.

ONE PER DAY LIMITATION

Many oral surgeries are limited to once per day. This limitation may be exceeded if narrative on the claim form demonstrates the additional services were medically necessary.

ADA/CPT ORAL SURGERY BILLING OPTIONS

Medicaid-certified dentists can select the procedure coding system they want to use for billing all oral surgery codes that do not require a tooth letter or number. Dentists can select either:

- The American Dental Association (ADA) Current Dental Terminology.
- The *Physicians' Current Procedural Terminology* (CPT).

The narrative below outlines the way that oral surgery procedure code billing is automatically assigned to dentists and provides an opportunity for dentists to choose a different billing system than they are assigned.

ASSIGNMENT OF ORAL SURGERY BILLING

Assignment of oral surgery billing depends on the dental specialty chosen during Medicaid certification. This assignment is necessary because it provides the fiscal agent's computers both a systematic way to identify the oral surgery procedure codes a provider can bill and a way to ensure accurate reimbursement.

SPECIALTIES BILLING CPT

This means that dentists with the following specialties are required to bill CPT procedure codes for oral surgeries that do not require tooth modifiers:

- Oral surgeons.
- Oral pathologists.
- Other dentists who indicate they want to bill CPT codes (using the form in Appendix 2 of this handbook).

SPECIALTIES BILLING ADA

The following specialties are required to bill ADA procedure codes for all oral surgeries:

- Endodontic.
- Orthodontics.
- Periodontics.
- Oral surgeons/pathologists who indicate they want to use ADA codes (using the form in Appendix 2 of this handbook).
- General practice.
- Pedodontics.
- Prosthodontics.

The chart in Appendix 2 of this handbook provides further clarification of this policy.

CHOOSING DIFFERENT BILLING

Any dentist who wants to elect a different billing specialty than currently chosen may do so by completing the form in Appendix 2 of this handbook.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

MD/DDS

When a provider is licensed as both a D.D.S. and M.D., Wisconsin Medicaid encourages the provider to enroll as a dentist (provider type 27 - oral surgery specialty 041).

IDENTICAL POLICIES AND REIMBURSEMENT FOR ALL DENTISTS

All dentists, regardless of specialty:

- Receive the same reimbursement for the same procedures.
- Have virtually the same program limitations, such as PA requirements, for the same procedures.
- Will bill all other dental (non-surgical) procedures using ADA procedure codes and a few Wisconsin Medicaid HCPCS local procedure codes (W codes).
- Must bill for all oral surgeries using the code system assigned at certification or chosen by completing the attached form.
- Cannot temporarily alternate between coding systems, using different procedure codes on different days.
- Can change their designated coding system anytime by completing the attached form.
- Will find that CPT billing requires fewer attachments and is easier to bill electronically.

DECREASED ATTACHMENTS AND CLAIMS PROCESSING TIME

The CPT coding system is more precise than the ADA coding system for describing the same oral surgery procedures. Therefore, most CPT codes do not require operative and pathology reports for manual pricing by the Medicaid dental consultant as well as the additional time needed for processing manually priced claims. This will facilitate electronic billing.

ORAL SURGERY BILLING USING ADA PROCEDURE CODES

ADA PROCEDURE CODES

The ADA and local HCPCS oral surgery procedure codes that are covered by Wisconsin Medicaid are listed in Appendix 16 of this handbook.

WISCONSIN MEDICAID CLAIM FORM

When ADA and HCPCS codes are used to bill Wisconsin Medicaid, the ADA claim form must be used.

ASSISTING SURGEON

Dentists billing ADA procedure codes will need to bill for the assisting surgeon as follows:

- If a procedure requires PA and an assisting surgeon will be used, request approval for both at the same time.
- Use the prior authorized TMJ assisting surgeon code (W7998) for TMJ surgery.
- With PA, surgical assistance may be paid under procedure code 07999.

ORAL SURGERY BILLING USING CPT PROCEDURE CODES FOR PROCEDURES THAT ARE NOT TOOTH SPECIFIC

CPT PROCEDURES

Appendix 19 of this handbook contains a complete list of all the CPT procedure codes that are covered in Wisconsin Medicaid dental benefit. Oral surgeons, oral pathologists, and dentists electing CPT billing use these codes instead of the ADA oral surgery codes that do not require tooth modifiers.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

HCFA 1500

The HCFA 1500 claim form must be used when using a CPT procedure code for billing. If a dentist provides both ADA and CPT procedures for a single patient, both may be billed on the HCFA 1500 claim form. The only ADA codes that cannot be billed on the HCFA 1500 claim form are restorative codes that require tooth surface information. Appendix 29 of this handbook contains HCFA 1500 billing instructions.

DIAGNOSIS

An *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code is always required in element 21 when using CPT codes on the HCFA 1500 claim form.

ASSISTING SURGEON

An assisting surgeon is allowed for some complex surgery procedures as noted on the chart in Appendix 19 of this handbook. To bill for an assisting surgeon, put the modifier "80" in element 24I of the HCFA 1500. If a procedure requires PA and an assisting surgeon will be used, request approval for both at the same time.

TMJ SURGERY PROCEDURES AND MANAGED CARE PROGRAMS

Medicaid-contracted managed care programs that cover dental services are responsible for providing a multidisciplinary evaluation at a facility of their choice to determine the necessity of TMJ surgery. If the surgery is approved, the managed care program may designate the facility at which the surgery is performed. The managed care program is responsible for paying the cost of the surgery and all related services (e.g., hospitalization, anesthesiology).

Wisconsin Medicaid does not reimburse for a TMJ surgery billed by a dentist on a fee-for-service basis when provided to a Medicaid recipient enrolled in a Medicaid-contracted managed care program which covers dentistry. Therefore, dentists must participate in or obtain a referral from the recipient's managed care program since the managed care program is responsible for paying the cost of all services. Failing to obtain a managed care program referral may result in a denial of payment for services by the managed care program. Refer to the Wisconsin Medicaid Managed Care Guide for more information.

If a Medicaid-contracted managed care program does *not* cover dental services, the multidisciplinary evaluation must be performed at a multidisciplinary evaluation facility designated by the DHFS. The dentist may submit a PA request to the fiscal agent and, if approved, the dental surgeon is reimbursed for the evaluation on a fee-for-service basis.

- Refer to the Wisconsin Medicaid Managed Care Guide and Appendices 20, 21, and 22 of Part A, the all-provider handbook, for a list of Medicaid-contracted managed care programs and services that can be billed fee-for-service.
- If surgery is recommended and the PA is approved, the managed care program is responsible for paying the cost of all related medical and hospital services and may therefore designate the facility at which the surgery is performed.
- The dentist must work closely with the managed care program to ensure continuity of coverage.

Appendix 16
Oral and Maxillofacial Surgery Services
(continued)

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted*. Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered oral and maxillofacial surgery services, procedure codes, and related limitations.
- Appendix 31 of this handbook for a summary of required billing documentation.
- Appendix 24 of this handbook for a summary of required documentation needed for PA requests.